

TREATMENTS OF SCHIZOPHRENIA

We now turn to a discussion of various treatments of schizophrenia. The treatment of this devastating illness typically involves medication, and some form of therapy and/or rehabilitation. It is fortunate that all approaches used to treat schizophrenia today are more effective than ever before. The new drugs have fewer side effects, and the psychological interventions target specific impairments.

Occasionally, people suffering from schizophrenia come for treatment on their own. But this is not common, because the illness is associated with impairments in judgment and insight (Smith, Hall and Satos, 1998). As we mentioned above, many patients deny their symptoms and insist they are not mentally ill. As a result, most receive their first treatment at the urging of friends or family members who are worried about the person's well-being. And too often they are brought to emergency rooms by the police because their symptoms are disturbing to others.

A major problem with any kind of treatment for schizophrenia is that many patients with schizophrenia lack insight into their impaired condition and refuse any treatment at all (Amador et al., 1994).

ELECTROCONVULSIVE THERAPY

Von Meduna observed that schizophrenia and epilepsy appeared to be biologically incompatible, that is, schizophrenia rarely occurred in epilepsy and vice versa. Drawing on his observation that those psychotic individuals prone to epilepsy showed less severe symptoms following an epileptic fit, Von Meduna advocated inducing major epileptiform fits in psychotics in order to 'drive out' and hence 'cure' their schizophrenia.

Electroconvulsive therapy (ECT), previously known as electroshock, is a well-established, albeit controversial, psychiatric treatment in which seizures are electrically induced in anesthetized patients for therapeutic effect. Prior to ECT treatment, a patient is put to sleep using general anesthesia and a muscle relaxant is given. Electrodes are placed on the patient's scalp and a finely controlled electric current is applied which causes a brief seizure in the brain.

Because the muscles are relaxed, the seizure will usually be limited to slight movement of the hands and feet. Patients are carefully monitored during the treatment and awaken minutes later, not remembering the treatment or events surrounding it. The patient is often confused, but this confusion typically lasts for only a short period of time. ECT is usually given up to three times a week for two to four weeks.

Typically, a number of ECT treatments occurring over several weeks will be administered, the total number being gauged by the individual's response (Freeman, 1995). Although ECT was originally used to treat schizophrenia, its usefulness with that disorder has been seriously questioned, and today it finds its primary use in the treatment of severe depression, bipolar disorder and certain obsessive-compulsive disorders. According to Wesseley (1993), ECT is 'highly effective' in the treatment of severe depression and particularly useful with those who harbour suicidal feelings because its effects are immediate

ECT has also been criticised on ethical grounds. Some opponents of ECT (e.g. Heather, 1976) have described the therapy as being 'about as scientific as kicking a television set because it is not working'. Certainly, the primitive methods once used were associated with bruises and bone fractures (as a consequence of the restraint used by nursing staff during the convulsion) and with pain when an individual failed to lose consciousness during the treatment. → evaluation

DRUG THERAPIES

THE NEUROLEPTICS:

The neuroleptics were the forerunners of the 'drug revolution' in the treatment of mental disorders. They were introduced in the 1950s following the accidental discovery by French researchers that they calmed psychotic individuals. Since they lessened the need for physical restraint (such as straitjackets) of seriously disturbed individuals, they were seen as a great advance in treatment. Neuroleptics are also known as major tranquilizers, although this term is misleading because they generally tranquillize without impairing consciousness. The term antipsychotics is also used to describe them because they are mainly used to treat schizophrenia and severe disorders, such as mania.

They are effective in reducing the positive symptoms of schizophrenia, which allows other forms of therapy to be used when the symptoms are in remission. However, some people fail to respond to the drugs, especially those displaying the negative symptoms of schizophrenia, such as apathy and withdrawal. The drugs do not cure, but reduce the prominent symptoms of schizophrenia. Relapse occurs after several weeks if the drugs are stopped. Additionally, neuroleptics are of little value in treating social incapacity and other difficulties in adjusting to life outside the therapeutic setting. As a result, relapse is common. → evaluation

The medications used in the treatment of schizophrenia are known as antipsychotics. These medications for schizophrenia don't provide a cure; rather they work by reducing the psychotic symptoms of the illness. The antipsychotic medications are particularly effective at controlling the positive symptoms of schizophrenia, including hallucinations, delusions, and disordered thinking. They are less helpful for treating the negative symptoms of schizophrenia, such as social withdrawal, lack of motivation, and lack of emotional expressiveness.

As with all medications, the antipsychotics affect people differently. It's impossible to know ahead of time how helpful a particular antipsychotic will be, what dose will be most effective, and what side effects will occur. Finding the right drug and dosage for schizophrenia treatment is a trial and error process. It also takes time for the antipsychotic medications to take full effect.

Some symptoms of schizophrenia may respond to medication within a few days, but others take weeks or months to improve. In general, most people see a significant improvement in their schizophrenia within six weeks of starting medication. If, after six weeks, an antipsychotic medication doesn't seem to be working, the doctor may increase the dose or try another medication.

Since most people with schizophrenia require medication for extended periods of time—often for life—the goal is to find a medication regimen that keeps the symptoms of the illness under control with the fewest side effects. Antipsychotic medication should never be discontinued without first consulting the doctor. Sudden or unsupervised dosage changes are dangerous, and can trigger a schizophrenia relapse or other complications.

The oldest antipsychotic medications are known as conventional or typical antipsychotics. They are believed to work by blocking dopamine receptors in the brain. While these first-generation schizophrenia medications effectively reduce the positive symptoms of the illness, they are prescribed less frequently today because of the neurological side effects—known as *extrapyramidal* symptoms—they often cause.

Common extrapyramidal side effects of the typical antipsychotics include:

- Restlessness and pacing
- Extremely slow movements
- Tremors
- Painful muscle stiffness
- Temporary paralysis
- Changes in breathing and heart rate

Conventional antipsychotics were introduced in the 1950's and all had similar ability to relieve the positive symptoms of schizophrenia. Most of these older "conventional" antipsychotics differed in the side effects they produced. These conventional antipsychotics include chlorpromazine (Thorazine), fluphenazine (Prolixin), haloperidol (Haldol), thiothixene (Navane), trifluoperazine (Stelazine), perphenazine (Trilafon), and thioridazine (Mellaril).

GROUP THERAPY

Group therapy, combined with drugs, produces somewhat better results than drug treatment alone, particularly with schizophrenic patients. Positive results are more likely to be obtained when group therapy focuses on real-life plans, problems, and relationships; on social and work roles and interaction; on cooperation with drug therapy and discussion of its side effects; or on some practical recreational or work activity. This supportive group therapy can be especially helpful in decreasing social isolation and increasing reality testing (Long, 1996).

FAMILY THERAPY

Family therapy can significantly decrease relapse rates for the schizophrenic family member. In high-stress families, schizophrenic patients given standard aftercare relapse 50-60% of the time in the first year out of hospital. Supportive family therapy can reduce this relapse rate to below 10 percent. This therapy encourages the family to convene a family meeting whenever an issue arises, in order to discuss and specify the exact nature of the problem, to list and consider alternative solutions, and to select and implement the consensual best solution. (Long, 1996).

COGNITIVE THERAPY

Cognitive behavioral therapy is useful for patients with symptoms that persist even when they take medication. The cognitive therapist teaches people with schizophrenia how to test the reality of their thoughts and perceptions, how to "not listen" to their voices, and how to shake off the apathy that often immobilizes them. This treatment appears to be effective in reducing the severity of symptoms and decreasing the risk of relapse.

As we noted earlier, the first stage in therapy is for the individual to recognize and question their irrational beliefs. Rather than remaining 'anonymous', as a classical psychoanalyst would do, and occasionally offering some form of interpretation, the rational-emotive therapist will show the person how to ask questions.

Once people have recognized and analyzed their beliefs, they are taught to substitute more realistic alternatives in an attempt to engender full acceptance. Rather than measuring themselves against an impossible standard, a rational-emotive therapist emphasizes that failures should not be seen as 'disastrous', confirming a lack of self-worth, but merely as 'unfortunate' events. Lange & Jakubowski (1976) have presented some rational alternatives to the beliefs therapists frequently encounter.

Ellis and his colleagues use a variety of approaches to try and minimize people's self-defeating beliefs. Rather than focusing on people's histories, rational-emotive therapists focus on the 'here and now'.

Indeed, by providing people with warmth, support, attention and caring, their need for love (which is usually the central core of their circumstances: Elkins, 1980) is reinforced. There is also the possibility that people become dependent on the therapy and the therapist.

Brandsma et al (1978) have reported that rational-emotive therapy (RET) is effective in producing behaviour change amongst those who are self-demanding and who feel guilty for not living up to their own standards of perfection.

BEHAVIORAL THERAPY

In an early demonstration that positive reinforcement can produce changes in the behaviour of disturbed individuals, Isaacs et al (1960) described the case of a 40-year-old male schizophrenic who had not spoken to anyone for 19 years. Quite accidentally, one of the therapists discovered that the man loved chewing gum, and decided to use this as a way of getting him to speak.

Initially, the therapist held up a piece of gum. When the patient looked at the gum, it was given to him. The patient began to pay attention to the therapist and would look at the gum as soon as the therapist removed it from his pocket. Later, the therapist held up the gum and waited until the patient moved his lips. When this occurred, the gum was immediately given to the patient. However, the therapist then began to give the gum only when the patient made a sound. At the point when the patient reliably made a sound when the gum was shown, the therapist held the gum and instructed the patient to 'say gum'. After 19 years of silence, the patient said the word. After six weeks of this therapy, the patient spontaneously said 'Gum, please', and shortly afterwards began talking to the therapist.

This approach is known as behaviour **shaping** and has been used with several types of disturbed individual, most notably the chronically disturbed and mentally retarded, who are extremely difficult to communicate with.

In a study published in 1962, Ayllon and Haughton reported that staff at one hospital found it particularly difficult to get withdrawn schizophrenic individuals to eat regularly. Ayllon and Haughton noticed that the staff was actually exacerbating the problem by coaxing the patients into the dining room and, in some cases, even feeding them. The researchers reasoned that the increased attention was reinforcing the uncooperativeness of the patients and decided that the rules that operated in the hospital should be changed. For example, if patients did not arrive at the dining hall within 30 minutes of being called, they were locked out. Additionally, staff was no longer permitted to interact with patients at meal times. Because their uncooperative behaviour was no longer being reinforced, the patients quickly changed their eating habits. Then the patients were made to pay one penny in order to enter the dining hall. The pennies could be earned by showing socially appropriate target behaviours, and these also began to increase in frequency.

MS. WARDA KHAN

SCHIZOPHRENIA

Ayllon and Haughton's approach was refined by Ayllon & Azrin (1968) in the form of a **token economy** system. In this, disturbed individuals are given tokens in exchange for behaving in desirable ways. The therapist first of all identifies what patients like. This may include watching television, smoking cigarettes, and so on. When a productive activity (such as making a bed or socializing with other patients) occurs, patients are given tokens that can be exchanged for 'privileges'. The tokens therefore become conditioned reinforcers for desirable and appropriate behaviours.